Dr. Dalton Prickett, MD, FACS

Dr. J. Benjamin Tribble, MD, FACS

Dr. Zeid Keilani, MD, FACS

Blue Distinction® Center+ Bariatric

Weight Management Center Bariatric Program Agreement

I,____________________ DOB: ___/___/___, have enrolled into the Comprehensive Bariatric Surgical Program with the Palmetto Health USC Medical Group effective ____/____/____. I agree to follow and adhere to the following:

____ **SERVICES:** As a patient, I acknowledge that I have the use of in house dietitians, Bariatric Specialized Surgeons with supporting Nurse Practitioners, psychological counseling and behavior modification personnel, professionally facilitated support groups, and staying on track classes for life all residing through the Weight Management Facility which holds the Blue Distinction Center for Bariatrics. All surgeries will be conducted at Baptist Hospital, which holds the MBSAQIP Accreditation.

_____ **NON-COVERED CHARGES**: Nutrition supplements (vitamins/protein), Bariatric Medically Necessary Labs (mostly vitamin levels, TSH panel, drug/toxicology screening), H. pylori testing, pre-surgical dietary items, office visits with my surgeon (co-pay), surgery and endoscopy (EGD or Upper GI), co-payments and/or deductibles, inpatient and outpatient fees and any and all related surgery fees may all be items not covered by insurance and therefore are the responsibility of the patient.

____ **INSURANCE:** Insurance companies may request additional information that our office may not have on file. It will be my responsibility to gather the necessary information needed to properly handle my file and insurance approval. I am aware that many insurance companies require Cardiac Clearance, Pulmonary Clearance, Psychological Clearance, Primary Care Physician Clearance, and in some instances, 3-6 months of documented Medically Managed Weight Loss Attempts within 29-30 days of each appointment scheduled. I am also aware that my insurance company may change the specific criteria required for Bariatric Surgery without notifying the PHUSC Weight Management Center or me. If my insurance changes while I am in the program, I will notify the office as soon as possible. It is my responsibility as a patient to know my coverage details/requirements.

____ **CLEARANCES:** I am aware that some of the necessary clearances may require additional tests to be completed that may or may not be covered by my insurance. I understand that I will be responsible for any additional costs.

Palmetto Health USC
MEDICAL GROUP

1850 Laurel Street
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____ **CANCELLATIONS:** We request that any NON-EMERGENCY surgery cancellations be made 10 days prior to your surgery date or as soon as possible. Surgery dates will be rescheduled as time allows on the surgeon's schedule. I understand that another pre-operative appointment may be necessary.

____ **NO SHOWS APPOINTMENTS:** I understand the following no show penalties-

1st No Show = 15 day push back for reschedule

2nd No Show = 30 day push back for reschedule

3rd No Show = 45 day push back for reschedule

4th No Show = Dismissal from the Bariatric Program

____ **POST SURGICAL APPOINTMENTS AND ATTENDANCE:** I agree to keep all of my 12-month post-surgical appointments. If I am unable to keep an appointment, I will call and reschedule in advance. ANY instances of multiple NON-COMPLIANCE, NO SHOWS and/or appointments that are NOT rescheduled in advance may result in dismissal from the practice. I understand that I must attend post-operative sessions for one year after my surgery date and annually thereafter.

____ **CHILDREN:** Because of the nature of the office visits, I understand that I am not to bring children under the age of 12 years old during any of the group sessions to include dietary classes, behavioral health classes, individual behavioral health assessments, support group meetings, or other required group therapy sessions.

____ **PRE-OP CLASSES:** I agree to attend all required pre-surgical pre-op classes and sessions mandated by the surgeon and the bariatric dietary program, behavioral health, and additional counseling, if needed. I agree to attend the post-surgical Staying-On-Track class at least once per month for one year after my surgery.

____ **DIET\EXERCISE HISTORIES:** I acknowledge that my insurance company may mandate a detailed diet and or exercise history collection. I also understand that food journaling is a requirement of the program and I agree to keep a detailed food journal from the beginning of the program until one-year post bariatric surgery. This journal will be brought to all dietary appointments for review.

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____ **SMOKING CESSATION:** I understand that in order to obtain bariatric surgery that I must maintain a nicotine free lifestyle for life. I understand that the post-operative complications of smoking include, but are not limited to, increased risk of bleeding, bleeding of the staple/suture lines, and ulcers of the stomach. I consent to at minimum one nicotine test prior to surgery (for non-smokers) and two negative nicotine tests prior to surgery (for history of smoking) which may or may not be covered by my insurance.

____ **BEHAVIOR:** I agree to adhere to a professional behavior and demeanor when speaking to all staff members within the Weight Management Center in person, via phone, and/or email to include refraining from any derogatory language or swearing at staff members. Failure to follow this guideline could result in immediate dismissal from the program.

I acknowledge all of the above and will adhere to and comply with all requirements set forth by this program and my insurance company.

PATIENT SIGNATURE: ______________________________ DATE:____/____/____

WITNESS SIGNATURE: ______________________________ DATE: ____/____/____

On behalf of the Palmetto USC Weight Management Center staff, physicians and contracted personnel, we greatly appreciate your decision to entrust our center with your care. We look forward to taking on this journey side-by-side with you.

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